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June 30, 2008

The Honorable Matt Blunt
Governor of the State of Missouri
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Governor, in Executive Order 07-12 you charged state agencies administering health care programs to develop a plan to address transparency in the delivery and administration of health care. I am happy to forward the enclosed report, which shares the department's achievements and future plans to incorporate increasing levels of transparency into the MO HealthNet, MO HealthNet for Kids and Missouri Rx programs.

If you have any questions, please do not hesitate to contact me.

Respectfully,

Deborah E. Scott
Director

Enclosure

Health Care Transparency

in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

June 2008

Introduction

On March 2, 2007, Governor Blunt issued Executive Order 07-12. This executive order charged state agencies administering health care programs to develop a plan to address transparency in the delivery and administration of health care. This is the second report detailing how DSS is promoting transparency for the MO HealthNet, MO HealthNet for Kids and Missouri Rx Plan.

This DSS plan centers on current initiatives and implementation of Senate Bill (SB) 577 (2007), which enacts the Missouri Health Improvement Act of 2007. SB 577 is the culmination of the executive and legislative branches' work to change how publicly financed health care is delivered to Missourians.

The DSS plan focuses on these four areas from the executive order:

- *Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect patient privacy as required by law;*
- *Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;*
- *Support making information available regarding the prices for procedures or services under the program; and*
- *Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.*

This report is organized by these four areas.

What is health systems interoperability?

There is no one health care system; health care is delivered through an assortment of disconnected providers with varying levels of technological sophistication. The basic concept of interoperability is easily sharing data. Standards are set so one system can talk to another and they can exchange data accurately, efficiently and securely. By connecting providers and payers, we gain a data supply to dependably measure cost and quality. Dollars saved by minimizing redundancies can be redirected to improving care.

Health Systems Interoperability

- **MO Health Net's Electronic Health Records in CyberAccess℠** – More than 8,700 physicians and other health care providers use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed drugs. Physicians can electronically submit prescriptions and request pre-certification for imaging procedures and durable medical equipment. CyberAccess℠ improves efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate criteria. All of this is done in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. Plans include integrating CyberAccess℠ with existing provider-based electronic medical record systems, importing laboratory data, increasing functionality to allow physicians to input notes and phasing in additional services ensuring appropriate utilization and efficient use of funds.

Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect patient privacy as required by law

- **Medicaid Management Information System (MMIS)** – The MO HealthNet Division (MHD) is updating the current MMIS. Many enhancements will be available through a modernized system that will support information sharing among health care partners:
    - Enterprise Services Business Interfaces – These interfaces will simplify and standardize data exchanges between key business partners by providing the compatibility to integrate computer systems running on different platforms regardless of technology or location.
    - Metadata Management – This will promote data sharing between business partners by providing easy to understand data definitions that will enhance the accurate transfer of information between systems.
    - Electronic Health Records – This initiative will draw on participant health records from other insurance companies and providers to supplement the health information we have from MO HealthNet claims. This enhancement will harness more information so the accuracy of clinical edits and care management can be improved.
    - Real Time Transaction Processing – Claims adjudication information will be available to providers on a real time basis. Providers can review billing outcomes, determine when payments will be made, and access online primary payment information and online eligibility status.

- HIPAA Enhancements – The new MMIS will ensure compliance with nationally mandated standards designed to address security and privacy of health data.

The MMIS fiscal agent contract was awarded to Infocrossing HealthCare Systems on September 7, 2007. The metadata management and HIPAA enhancements will be implemented by January 2009. All other enhancements are scheduled to be completed by October 2010.

- **Managed Care Organizations (MCOs)** – MCOs, through a contracted relationship with the state, currently provide health care services for 382,588 people enrolled in the MO HealthNet Managed Care program. The MCOs have a sophisticated claims processing and management information system that interfaces with the state's MMIS. This provides valuable encounter data on managed care enrollees. The state, in conjunction with its contracted actuarial firm and external quality review organization, is undertaking reviews to improve the comprehensiveness and accuracy of encounter data for use as the primary data source for capitation rate development. These reviews will serve as a basis for implementing and improving best practices by the MCOs. Encounter data validation reviews by the actuarial firm will be an annual process as a part of capitation rate development.

- **Non-Emergency Medical Transportation (NEMT)** – NEMT is provided under a contractual relationship and, like the MCOs, the contractor is providing encounter data in a readable format that interfaces with the MMIS. The encounter data is tracked on a monthly basis to assure consistency. The MHD is working towards using encounter data for setting NEMT capitation rates in the future.

- **Electronic Medical Record (EMR) Interoperability** – DSS is exploring opportunities for electronic medical record interoperability to bridge the CyberAccess℠ tool with existing provider-based electronic medical records. In 2007, DSS contracted with BJC Healthcare to bring this concept to the metropolitan St. Louis region. As part of this project, physicians employed by BJC or BJC affiliates will share a common relational database of patient drug and clinical workflow information – all within HIPAA guidelines. Physicians will also have the ability to exchange relevant patient information with external labs and participating hospitals.

  In June 2008, BJC reported that 119 physicians were using the EMR system, with access to more than 532,000 patient records. The pilot project will end on December 31, 2008, and MHD and BJC intend to continue collaboration to pursue an ultimate goal of full interoperability.

- **Medicaid Transformation Grant - Development of a Web-Based Tool for Home and Community Based Services** - A Medicaid Transformation Grant was awarded to the MO HealthNet Division by the Centers for Medicare and Medicaid Services (CMS). This grant provides funding to develop an electronic assessment and services allocation tool for home and community based services. This tool is being developed through a cooperative effort with the Department of Health and Senior Services.

- **A Federally Qualified Health Center Health Information Technology Project** – A Statewide Safety Net Gap Analysis Survey was completed September 2007 with plans to develop and implement electronic health/medical records in each community health center. The requirements for a data warehouse that will provide a centralized location to examine benchmarks, best practices, and increase access to information from a normalized reporting platform have been developed.

  In SFY-2009, this data warehouse will be fully implemented. It will enable the Missouri Primary Care Association to report aggregated data across all the community health centers in the state. The implementation of the electronic health/medical records will be completed by June 2009.

- **An Electronic Medical Records Pilot for One or More Greene County Skilled Nursing Facilities** – Work is currently underway to implement the pilot project.

- **A Pilot for Telehealth for Rural Health Clinic Records –** MHD is working with the Missouri Telehealth Network (MTN) at the University of Missouri-Columbia. The MTN conducted a survey of rural health clinics around the state to assess their interest in telehealth, and identified approximately 20 sites that indicated a high level of interest. The MTN is working with each of these sites to connect them to the telehealth network.

- **Northwest Missouri Regional Electronic Medical Records project –** The General Assembly appropriated $500,000 for SFY-2009 to fund a regionally integrated electronic medical records system linking rural physicians and hospitals in Northwest Missouri. The project will provide a system which integrates health care records within a regional database and utilizes technology that can be easily be shared with other health providers, and may be replicated beyond its immediate population. The successful vendor will be required to provide at least $900,000 in matching contributions to the project.

- **Health Care Technology Fund** – SB 577 established the Health Care Technology Fund in statute, promoting technological advances to improve patient care, decrease administrative burdens, increase access to timely services and increase patient and health care provider satisfaction. Examples include:

    - Electronic medical records – This is currently under development.

    - Personal and community health records – This is currently under development.

    - E-prescribing – This is currently in place for certain providers and will be expanding to others over time.

    - Tele-medicine – This is currently under development.

    - Tele-monitoring – This is operational for participants meeting established criteria.

    - Electronic access for participants and providers to obtain service authorization. Provider access for specific procedures and equipment is currently available and will be expanding over time. The participant web portal is under development with expected completion date by the end of calendar year 2008.

Why is measuring health care provider performance important?

We want to spend our health care dollars where we will get the best care. Quality of care is of interest to everyone, but measuring it is complex. There is a void of publicly accessible, accurate information on cost and quality, so we are continuing our efforts to make information easier to access and easier to understand.

Quality of Provider Performance

- **Healthcare Effectiveness Data and Information Set (HEDIS)** – HEDIS is a tool used by more than 90% of America's health plans to measure care and service performance. HEDIS makes it possible to compare the performance of health plans on an apples-to-apples basis. Health plans use HEDIS to see where improvement is needed. Annually, DSS requires MCOs to submit independently audited HEDIS performance rates as specified by the National Committee for Quality Assurance (NCQA). The MO HealthNet managed care health plans' 2006 HEDIS data demonstrated improvement in adolescent immunizations; adolescent well care visits; annual dental visits-combined rate; asthma-combined rate; childhood immunization; chlamydia screening-combined rate; well child visits in the first 15 months; well child visits in the third, fourth, and sixth year of life; follow-up after hospitalization for mental illness within seven days of discharge; timeliness of prenatal care; and, post partum care.

Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services

- **Consumer's Managed Care Guide** – MCOs are evaluated on their commercial, MO HealthNet and Medicare product lines in the areas of access to care, quality of care and customer satisfaction. The Consumer's Managed Care Guide, published by the Department of Health and Senior Services (DHSS), takes this data and shares how well MCOs are delivering care and customer service to their members. This guide helps consumers, employers and other purchasers with their health insurance selection.

  The 2006 Consumer's Guide to Managed Care in Missouri (rating MCO performance during calendar year 2005) is available on the DHSS website at www.dhss.mo.gov/ManagedCare/mcaid_06.pdf. All seven of the MCOs ranked average to high in the area of children's health; six of the seven MCOs ranked average or high in the area of member satisfaction; and, four of the seven ranked high in the area of women's health services.

- **External Quality Review** – CMS requires an annual, independent, external evaluation of the MO HealthNet Managed Care program. An external quality review is an analysis of aggregate information on quality, timeliness and access to health care services furnished by MCOs and their contractors for MO HealthNet managed care recipients.

  The 2006 MO HealthNet Managed Care Program External Quality Review Report of Findings was issued in December 2007. Overall, the External Quality Review Organization (EQRO) found continued improvement by the MO HealthNet managed care health plans through validation of health plan performance improvement projects, performance measures, encounter data and compliance with managed care regulations.

- **1115 Waiver Evaluation** – **1115 Waiver Evaluation** – On April 28, 1998, CMS approved Missouri's Section 1115 Health Care Reform demonstration waiver, Managed Care Plus (MC+). This waiver initiative built on Missouri's very successful MC+ program by focusing on children. An annual evaluation is conducted by an external agency. The evaluation focuses on the collection and analysis of waiver population information and a study of the impact of policy decisions on enrollees and the uninsured.

  The 1115 waiver evaluation for the review period of September 1, 2005, through August 31, 2006, had the following conclusions:

  - The 1115 waiver helped keep the rate of uninsured children lower than the national rate. Without the 1115 waiver over 59,000 additional children would most likely be uninsured;
  - The 1115 waiver is having a positive effect on medical facilities and emergency rooms (ERs) (e.g., they have fewer avoidable admissions and there are fewer children using the ER when a visit to a physician is more appropriate); and,
  - Given the inconclusive nature of research done in the area of crowd out, no conclusion could be drawn in this area. It is important to note that the Missouri General Assembly's action to extend premium and affordability requirements to a greater portion of Missouri's SCHIP population has provided mechanisms to address crowd out.

  Effective September 1, 2007, Missouri's uninsured children's program was moved from the 1115 waiver to the State Children's Health Insurance Program (SCHIP) state plan.

  On October 15, 2007, CMS approved Missouri's Section 1115 demonstration waiver, Women's Health Services Program, effective October 1, 2007. Under this waiver, Missouri will provide approved family planning services to uninsured (defined as not having creditable coverage) postpartum women ages 18 to 55 who are losing their MO HealthNet eligibility 60 days after the birth of their child. Additional funding was received for SFY-2009 to expand coverage to women with net family income at or below 185% of the federal poverty level. It is estimated that an additional 83,000 women will receive coverage. An annual evaluation will be conducted by an external agency.

- **Home and Community Based Quality Strategy** – Missouri operates seven Home and Community Based Services (HCBS) waivers which allow individuals to remain in their communities and avoid institutionalization:
  - Aged and Disabled Waiver – Homemaker/chore, respite, home delivered meals and adult day care services to individuals aged 63 or over;
  - AIDS Waiver – Expanded personal care services, private duty nursing, attendant care and supplies for individuals diagnosed by a physician as having AIDS or an HIV-related illness;
  - Independent Living Waiver – Expanded personal care services, environmental accessibility adaptations, specialized medical equipment and supplies and case management for individuals age 18 to 64 who have a cognitive and/or physical disability;

- Mentally Retarded and Developmentally Disabled Waiver (MR/DD) – Residential and day habilitation, individualized supported living, behavioral/physical/occupational/speech therapy, respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, home modification and adaptive equipment services to individuals who have mental retardation and/or a developmental disability;

- Missouri Children with Developmental Disabilities Waiver (MOCDD) – Day habilitation, behavioral therapy, respite, personal assistant services, community specialist services, crisis intervention, transportation, environmental accessibility adaptations and specialized medical equipment and supplies to individuals age birth to 18 who have a developmental disability and whose families have chosen to have the child remain at home;

- Consumer Support Waiver – Day habilitation, individualized supported living, behavioral/ physical/occupational/speech therapy, respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, home modification and adaptive equipment services to individuals who have mental retardation and/or a developmental disability and receive substantial unpaid support from family members; and,

- Physical Disabilities Waiver – Attendant care services, private duty nursing and specialized medical equipment/supplies to individuals who have serious and complex medical needs age 21 or older and are no longer eligible for services under the Healthy Children and Youth program.

The MO HealthNet Division maintains a Quality Management Strategy (QMS), which demonstrates to the federal government that DSS retains administrative authority of the HCBS waiver programs, and has systems in place to measure and improve its performance in meeting the waiver assurances. These systems assure participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction and system performances.

- **MO HealthNet Managed Care Annual Report** – Each year evaluations of the MCOs in the MO HealthNet Managed Care program are performed. The evaluation contains information concerning the effectiveness and impact of the MCOs' MO HealthNet quality assessment and improvement strategy. The evaluation also reports on compliance with state, federal and MO HealthNet contractual requirements.

  The SFY-2006 MO HealthNet Managed Care Annual Evaluation was presented at the MO HealthNet managed care Quality and Assessment (QA&I) Advisory Group and All Plan meetings in January 2007. Evaluation of network adequacy; travel distance; consumer assessment of health care providers and systems (CAHPS); HEDIS indicators; provider surveys; performance improvement projects; and compliance with fraud and abuse, credentialing and recredentialing, subcontractor oversight and federal rule compliance revealed a continued commitment of the health plans to provide quality health care to their participants.

- **Hospital Quality Initiative** – This initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The intent is to improve quality of care by distributing objective, easy to understand hospital performance data. This will encourage consumers and their physicians to discuss getting the best hospital care, create incentives for hospitals to improve care and support public accountability.

  CMS is working in conjunction with the Hospital Quality Alliance (HQA), a public-private collaboration on hospital measurement and reporting. Among the collaborators are the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges. The collaboration is supported by the Agency for Healthcare Research Quality (AHRQ), CMS, the National Quality Forum, Joint Commission on Accreditation of Healthcare Organizations, American Medical Association, Consumer-Purchaser Disclosure Project, AFL-CIO, AARP and the US Chamber of Commerce. Through this initiative, a robust, prioritized and standardized set of hospital quality measures has been refined for use in public reporting. The Missouri Hospital Association is leading this effort in Missouri.

  From 2003 through today, the national average of the scores has steadily improved with public reporting. A report on hospital charges and collections may be found at www.focusonhospitals.com.

  For SFY-2009, hospitals will be collecting 30 measures including heart attack, pneumonia, and heart failure for the surgical care improvement project (SCIP). CMS publicly displays this data on its Hospital Compare web site, http://www.hospitalcompare.hhs.gov.

- **Quality and the Chronic Care Improvement Program (CCIP)** – In addition to providing care management for chronically ill MO HealthNet patients, one of the key goals of the CCIP is to support health care professionals who are providing high-quality care to their patients. The CCIP health coaches and care coordinators work directly with patients and their physicians to provide support and reinforcement of patient education. Using Care Connection, an internet-based plan of care, all participants – patients, providers, and health coaches – are able to work together more effectively using a collaborative health record, which facilitates communication and information sharing.

  As of May 2008, approximately 105,000 participants, and many of their physicians, throughout the state were participating in CCIP. The Quality Improvement Council (QI), which is part of CCIP, has established a set of quality standards and benchmarks for treating patients with chronic diseases. These standards are used as the basis for a pay-for-performance project that is discussed below.

- **Pay for Performance (P4P)** – The department, in conjunction with the Professional Services Payment Committee, will be developing guidelines to implement pay for performance that will reward providers for quality care. The Center for Health Care Strategies (CHCS) selected MO HealthNet to participate in the Pay for Performance Purchasing Institute. Institute participants receive technical assistance from CHCS and other collaborators in areas such as developing incentive structure, choosing measures and engaging providers.

Through CCIP, a Quality Improvement Council is working with providers from around the state to develop measures and standards for a pay for performance program. This work may serve as a foundation for the Professional Services Payment Committee to expand P4P for the broader population. The initial CCIP P4P payment, issued to providers in the second quarter of 2008, was developed based on provider's individual results for several standard, peer-reviewed and best-practice clinical outcomes for each of the participant's conditions managed through CCIP. These best practices include use of inhaled corticosteroids for asthmatics, regular acquisition of glycosylated hemoglobin values and screening ophthalmology examinations for diabetics, use of beta blockers and ACE inhibitors for participants with congestive heart failure, measurement of lipid profiles for participants with coronary artery disease, and annual influenza immunizations. Subsequent P4P payments are expected to be issued on a quarterly basis for the CCIP.

- **Health and Wellness Outcome Survey** – SB 577 provides for the department to commission an independent survey to assess health and wellness outcomes of participants. Components include:
  - Disease-specific outcome measures;
  - Provider network demographics;
  - Provider availability for participants compared to the statewide population; and,
  - Provider and participant program satisfaction.

  The report will be commissioned by July 1, 2008, with an expected completion by December 31, 2008.

Why is sharing health care pricing important?

Freely sharing pricing information is necessary to control costs. We need reliable information so both consumers and government can make valid price comparisons and get the most from their health care dollar.

Sharing Health Care Pricing

- **MO HealthNet Fee Schedules** – MO HealthNet Division on-line fee schedules are updated quarterly and are available at www.dss.mo.gov/mhd/providers/index.htm. These schedules identify covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit.

- **State Children's Health Insurance Program (SCHIP) Premium Schedule** – Individuals in families with income above 150% of the federal poverty level share costs through monthly premiums. Families pay no more than 5% of their annual income for premiums in a year. The premium amounts change effective July 1 of each year. The premium amounts are calculated according to state law (the state budget and MO Revised Statute Section 208.640). Monthly invoices are sent to those individuals owing a premium. Individuals who have questions about premiums should call the Premium Collections Unit at 1-877-888-2811. The premium schedule is posted on the web site, www.dss.mo.gov/mhd/providers/pdf/puzzledterm.pdf.

  Support making information available regarding the prices for procedures or services under the program

- **MO HealthNet Managed Care Rates** – Capitation payments are the only payments made to MCOs for contracted services. The MCO capitation rates are public information, which can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management. MHD will be posting the rates on its website in the near future.

- **Non-Emergency Medical Transportation (NEMT) Rates** - The NEMT provider capitation payment is the only payment made for contracted services. NEMT capitation rates are public information and can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management. MHD will be posting the rates on its website in the near future.

- **Pricing for Procedures and Services –** In January 2007, MoRx Price Compare (http://www.morxcompare.mo.gov/) was launched. MoRx Price Compare uses information captured through the MO HealthNet claims process to create a user-friendly, web-based tool that allows consumers to comparison shop using retail prescription prices. County, city, zip code and area comparisons can be made.

  Since its launch in 2007, over 36,000 search sessions have been initiated. There are ongoing discussions with the Missouri Hospital Association about developing a similar tool allowing consumers to see the relative efficiency and efficacy of hospitals.

- **Medicare and Dental Rates** – SB 577 requires the department to report each January 1 on the status of reimbursement rates compared to 100% of Medicare rates and average reimbursement for dental services by third party payers. The department is also required to present a four-year plan to the General Assembly to achieve parity with Medicare and third party dental rates. The department will be submitting the plan by July 1, 2008.

- **Nursing Home and Hospital MO HealthNet Rates** – The department is studying the possibility of posting to the Internet nursing home and hospital MO HealthNet rates.

Why is rewarding quality important?

We have a capitalistic society. For every MO HealthNet service there is a maximum fee, but historically we have made no payment distinction between good and bad care. To safeguard our health care we need to balance keeping quality providers in the system with cost effectiveness. To encourage quality, we need to reward providers who practice good medicine and consistently meet established standards of care.

Cost-Effectiveness, Consumer Involvement and Provider Rewards

- **MO HealthNet Managed Care Early Periodic Screening, Diagnosis and Treatment (EPSDT) Adjustments** – In accordance with CMS guidelines, DSS requires 80% of eligible MO HealthNet Managed Care members to have Healthy Children and Youth (HCY)/EPSDT well child visits. DSS measures the MCOs' performance using these well child visits and prorates the monthly capitation payment based on their effectiveness.

  During SFY-2005, 162,371 children (61.9% of eligible children) in the MO HealthNet Managed Care program received an HCY/EPSDT screening. During SFY-2006, 163,450 children (75.9% of eligible children) in the MO HealthNet Managed Care program received an HCY/EPSDT screening. During SFY-2007, 165,241 children (72.3% of eligible children) in the MO HealthNet Managed Care program received an HCY/EPSDT screening.

> *Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results*

- **MO HealthNet's Chronic Care Improvement Program (CCIP)** – CCIP is a coordinated health care model for the most seriously ill seniors and persons with disabilities. CCIP began in November 2006 and is a voluntary choice for sufferers of long-term chronic diseases, including diabetes, asthma, chronic obstructive pulmonary disease, gastroesophageal reflux disease, sickle cell disease and cardiovascular disease. CCIP maximizes health information technology by allowing treating providers to access patient's entire medical history through an electronic health record. This is a prized function that the web-based tool, CyberAcess℠, adds to electronic prescribing, diagnosis data, ability to receive alerts, selection of appropriate medications, and drug and medical prior authorizations. These tools allow collaborative communication among providers about patient care – reinforcing the provider's treatment and improving the participant's quality of care.

  As of May 2008, approximately 105,000 participants were enrolled in CCIP, along with many of their physicians. Physicians participating in CCIP as caregivers received their first pay for performance payments in the second calendar quarter of 2008.

- **High Quality and Cost-Effective Health Care** – The General Assembly appropriated funding to increase the pharmacy reimbursement rate to provide for medication therapy management. This function allows pharmacists to take a more active role in managing MO HealthNet patients' medication regimen. Through the use of a web-based tool called Direct Care Pro, trained pharmacists can provide additional education and information to participants, thus facilitating continuity of care.

- **Drug Utilization Review/Prior Authorization** – SmartPA™ uses a highly sophisticated clinical rules system in conjunction with drug and medical claims data to help pharmacists determine the appropriateness of dispensing certain medications. It streamlines the prior authorization process for all stakeholders – physicians, allied health professionals and participants. It adjudicates prior authorizations in real time. All providers who participate in MO HealthNet's fee-for-service program are subject to drug utilization review and prior authorization requirements. Smart MedPA™ technology was implemented in July 2006 based on SmartPA™ to process precertifications for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) of the chest. Imaging services are also processed through Smart MedPA™. The same technology is used to process prior authorizations for Durable Medical Equipment.

- **Fraud and Abuse** – The department uses Thomson Reuters Advantage Suite®, a comprehensive Fraud and Abuse Detection System (FADS), to identify patterns of inappropriate billing and potential fraud, waste or abuse of the MO HealthNet program. The tools available within the FADS include algorithms that are adapted for use with the MO HealthNet claims database. FADS is used for efficient case development by using its detailed or drill down reports, which identify specific provider and/or participant information to isolate specific claims data to review. The system allows the users to eliminate most false positive results and to concentrate on productive cases that were overpaid. FADS is used daily by the Program Integrity Unit (PIU) staff to run queries and perform research to identify claims. Cash recoveries and cost avoidance total $23.4 million for SFY-2006, $21.7 million for SFY-2007 and $23.2 million for SFY-2008 (through May 2008).

- **Long-Term Care Insurance Partnership** – Under these partnerships programs, individuals purchase long-term care insurance plans. When long-term care is needed, typically later in life, individuals will use the benefits afforded by the insurance plan. This will allow them to retain a certain amount of assets (assets equal to the amount of long-term care benefits paid on behalf of the individual through a long-term care partnership plan) and still qualify for MO HealthNet long-term care benefits, provided all eligibility requirements are met including resources. This type of program provides an incentive for consumers to be directly involved with health care decisions while protecting individual assets and reducing reliance on publicly funded programs.

  The Department of Insurance, Financial Institutions & Professional Registration's regulation on long-term care plans will be effective July 31, 2008. The Family Support Division will issue policy at that time.

- **Health Improvement Plans** – SB 577 provides for the establishment of a high quality and cost effective health care through three types of plans – risk bearing coordinated care (managed care), administrative service organization (non-risk bearing) and coordinated fee for service. Plans are to adhere to the principles of transparency, personal responsibility, prevention and wellness, performance based assessments, achievement of improved health care outcomes and cost effective delivery through technology and coordination of care. Throughout SB 577, references are made to *participants.* This is an important shift from the previous mindset of a *recipient*. Participants will have opportunities to increase their health literacy and become active partners with their health care home in improving and maintaining their health. The goal of a health care home is to assist participants and their support system in accessing primary care services, coordinating referrals and obtaining specialty care.

The MO HealthNet Division, in conjunction with the Office of Administration, released a request for proposal for an Administrative Services Organization to operate in Northwest Missouri in May 2008. A second request for proposal for an Administrative Services Organization for Southwest Missouri will be issued later this year. In addition to these two regional ASOs, MHD has worked with its CCIP vendor, APS Healthcare, to provide ASO services to the remainder of the state while work continues on a multi-year plan to implement regional ASOs across the state.

- **Pay for Performance (P4P)** – The department, in conjunction with the Professional Services Payment Committee, will be developing guidelines to implement pay for performance that will reward providers for quality care. The Center for Health Care Strategies (CHCS) selected MO HealthNet to participate in the Pay for Performance Purchasing Institute. Institute participants receive technical assistance from CHCS and other collaborators in areas such as developing incentive structure, choosing measures and engaging providers.

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- **Direct Inform** – In keeping with the goal of empowering participants to become more actively involved in their own health care, the MO HealthNet Division is working with its partners to develop a participant web portal allowing participants to access their medical claim payment information as well as a wide array of links to pertinent health-oriented websites. This portal will enable the participants to self report many treatments they may seek outside of the MO HealthNet benefit including over-the-counter medications, homeopathic treatments, etc. Direct Inform will be implemented and accessible to participants by December 2008.

- **Deficit Reduction Act of 2005 (DRA)** – MO HealthNet continues to be the payer of last resort. When another payer is liable for the personal injury, disability or disease of a MO HealthNet participant, benefits are assigned to the Department of Social Services, who pursues collection. The participant is required to aid in this pursuit. Provisions in Section 6035 of the DRA Act are now included incorporated into RSMo 208.215 and 208.217:

  - Within 60 days of receipt, a MO HealthNet participant who receives a third party benefit for a covered illness or injury is required to pay up to the total MO HealthNet benefits provided or place the full amount in a trust account pending final judicial or administrative determination.

  - Settlements cannot be reached in actions in which the MO HealthNet Division may have an interest without first giving the division notice.

  - Upon request by the MO HealthNet Division, all third party payers must provide the division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under HIPAA.

  - The Department of Social Services is not required to seek reimbursement from a liable third party when the recovery will be less than the cost of recovery.

- Third party administrators, administrative services organization and pharmacy benefit managers doing business in Missouri or administering or processing claims or benefits for residents are subject to MO HealthNet third party liability data match and must comply with HIPAA.

- Third party liability data may be requested at a minimum of twice per year.

- Unless waived by the MO HealthNet Division, a participant's probate estate cannot be closed until the personal representative of the estate files a release from the MO HealthNet Division evidencing payment of all MO HealthNet benefits, premiums, or other such costs due from the state under law with the court.

The MO HealthNet Division will be meeting with Missouri health insurance carriers to discuss topics including eligibility information exchange, data matching and claims payment.

- **MO HealthNet Responsibility Report** – In Executive Order 06-45, Governor Matt Blunt instituted the Missouri Health Care Responsibility Report. Starting with the first calendar quarter of 2008, 120 days after each quarter, Department of Social Services will prepare a report listing each employer in the state with 50 or more workers who are MO HealthNet participants, have a spouse who is a MO HealthNet participant or who are a custodial parent of a MO HealthNet participant. SB 577 (2007) moved this requirement to statute. The first report is scheduled for submission July 31, 2008.

Conclusion

DSS' successful implementation of the principles contained in the executive order to achieve transparency requires engaging all health care partners. Policy and contractual agreements will continue to embody these principles and to be continually scrutinized to ensure they incorporate the best in transparency practices. Standardized transparency language is being added to contracts as they are initiated or rebid.